1982

Robert B. Vance v. Paul V. Fordham : Brief of Appellant

Utah Supreme Court

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IN THE SUPREME COURT OF THE STATE OF UTAH

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ROBERT B. VANCE, D. O. Appellant and Plaintiff, vs. PAUL T. FORDHAM, Director of the Department of Registration, Department of Registration and the Osteopathic Committee, Respondents and Defendants.	* * * * * * * * * * * * * * * * *	No. 18176

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APPELLANT'S BRIEF

APPEAL FROM THE JUDGMENT OF THE
THIRD JUDICIAL DISTRICT COURT FOR SALT LAKE COUNTY
HONORABLE CHRISTINE M. DURHAM, JUDGE
AFFIRMING THE ORDER OF
THE DEPARTMENT OF REGISTRATION

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STATEMENT OF THE NATURE OF THE CASE

This is an action involving the revocation of the Plaintiff's license to practice medicine as an osteopathic physician and surgeon, by the Department of Registration. The revocation order was entered by the Department of Registration on February 2, 1981, at the conclusion of a hearing before the Osteopathic Committee. The committee recommended revocation of Dr. Vance's license, for "unprofessional conduct" under Utah Code Annotated 1953 § 58-12-36(15).

The decision was appealed to the District Court of Salt Lake County under the provisions of Utah Code Annotated 1953 § 58-1-36 by filing an "action" as provided.

DISPOSITION IN LOWER COURT

The District Court treated the appeal simply as a review, ordered the parties to file appeal briefs, and based upon a review of the transcript of hearing before the Osteopathic Committee, and the parties brief's, the District Court affirmed the order of the Department of Registration, concluding that "This Court may not substitute its judgment of factual matters for that of the fact finding body unless that body has acted capriciously or arbitrarily, or unless its conclusions are unsupported by the evidence."

Further, prior to the final ruling, the Plaintiff had discovered that one of the three member Osteopathic Committee was disqualified and barred from serving thereon under the provisions of Utah Code Annotated 1953 § 58-1-6. A motion to

dismiss was immediately filed with the District Court and the Court ruled that although the member was disqualified, she was a de facto officer acting under color of law, and even if the decision was voidable, because of the lack of qualification of one committee member, the point was raised for the first time on appeal, and is therefore untimely.

RELIEF SOUGHT ON APPEAL

The Plaintiff seeks the reversal of the revocation order and to have the Plaintiff's license to practice medicine restored as a matter of law, or in the alternative to have the matter remanded for a trial before the District Court.

STATEMENT OF FACTS

This matter is an appeal from an order entered February 2, 1981, by the Department of Registration revoking the professional license of the Plaintiff, Dr. Robert B. Vance, to practice medicine as an osteopathic physician and surgeon. The order was made pursuant to the recommendation of the three member Osteopathic Committee appointed pursuant to the provisions of Utah Code Annotated 1953 § 58-1-5 and 6.

The Department of Registration originally filed a Complaint against the Plaintiff, alleging acts of unprofessional conduct in regard to 35 of the more than 8000 patients the Plaintiff has successfully treated over the past ten years of his practice. [Record p. 173-189] Included in the 35 patients were three "bogus" patients who were sent to the Doctor, one by

a local television station, to obtain chelation treatments, and who admittedly falsefied her medical history to the Doctor to obtain said treatment. Of the 35 patients included in the Complaint, many refused to testify against the Plaintiff, and the committee received evidence on only 9, and made adverse findings on only 8 of the patients, including the three "non patients."

Dr. Robert B. Vance has a distinguished professional background, nationally recognized in the field of Preventative Medicine. He obtained a B.S. Degree with a major in Biochemistry from Beloit College, Beloit, Wisconsin in 1954. He then studied at the prestigious Kirksville College of Osteopathic Medicine in Kirkville, Missouri graduating in June 1958. He then completed a full time rotating internship averaging 92 hours per week on duty at the Bay Osteopathic Hospital, Bay City, Michigan. He is licensed in the States of Michigan, Indiana, Ohio, Missouri and Utah.

In 1961 he commenced his full time practice in the State of Utah, where he has continuously practiced medicine on a full time basis during the past 21 years, placing great emphasis in his practice upon preventative medicine and nutrition in the care and treatment of his patients. [Record p. 981-983] Over the period of 20 years the Doctor has dedicated literally hundreds of hours to research and study with many of the leading practitioners and pioneers in the field of medicine [Record p. 984-989] averaging 8-10 medical conventions and seminars each year to advance his medical knowledge and ability in order to

bring aid and comfort to suffering patients. The Doctor testified that any of the modalities or therapies included in his practice have been studied by him for a minimum of three years. [Record p. 906] Among many of his distinguished accomplishments, he has been certified by the American Academy of Medical Preventics, as a Diplomate in Chelation Therapy. [Record p. 1171]

In spite of the specialized, exhaustive and extensive studies and training, the record reveals an overt bias and prejudice on the part of the three osteopaths below as to the modalities employed by Dr. Vance.

The three members of the Osteopathic Committee consisted of the following: Dr. Katherine V. Greenwood, Dr. Leland W. Shafer and Dr. Kago Hase.

It is admitted, that Dr. Greenwood was unqualified to sit as a member of the Osteopathic Committee. She was sworn in a member of the committee on January 5, 1981, the first day of the hearing herein. [Record p. 139] However she was first licensed to practice in Utah on June 6, 1978, some two years and 7 months before her appointment to the committee (Statute requires 5 years). [Record p. 140] At the date of her application for licensing on April 19, 1978 she was a resident of Iowa (Statute requires 3 years residency). [Record p. 141-142] The knowledge of her disqualification was learned by Plaintiff for the first time during the appeal.

The committee held hearings in Salt Lake County, based upon the petition of the Department of Registration. Of the 35

patients regarding whom Complaints were made, findings were made on only 8 of these former patients, involving the charge that Dr. Vance improperly diagnosed and treated these patients for conditions that did not exist; or used procedures or methods not accepted by the standards of the profession; or that he failed to follow the standards of the profession; and specifically concluding that the use of Chelation Therapy, or the prescribing of Laetrile (Amygdalin B-17), or the use of Kinesiology to test for food alergies, are unacceptable methods of practice by "medical standards". [Record p. 170-172]

The findings were supported by hearsay testimony of the former patients and three MD's and one D.O. who testified as to their findings in treatment of the patients. However three noted physicians testified that the methods of practice used by Dr. Vance although not used in the mainstream of MD's in practice today, are clearly accepted methods of treatment and widely used throughout the United States today by hundreds of Doctors who are involved in preventative medicine. [Record p. Dr. Gordon p. 623-793; Dr. Halstead p. 1110-1174, Dr. Gerber p. 1007-1104]

Nevertheless, the Committee recommended revocation, and based thereon the Department of Registration issued the revocation order on February 6, 1981. [Record p. 169]

The Plaintiff then filed its appeal action in the District Court of Salt Lake County. During the pendency of the appeal, the Plaintiff discovered the fact that Dr. Greenwood, one of the three osteopaths who served on the committee, was

unqualified to serve as a member, as provided by the statute. Plaintiff immediately filed a Motion to Dismiss based on the grounds that the committee was never duly constituted under the provisions of Utah Code Annotated 1953 § 58-1-5 and 6 [Record p. 79] and its decision must therefore be void.

After arguments to the Court, the Court denied Plaintiff's Motion to Dismiss, concluding that although Dr. Greenwood was disqualified to be appointed, she was a de facto officer, that even without Dr. Greenwood's vote, a majority of the committee (2) recommended the revocation; and even if the decision were voidable, Appellant's motion was not timely because it was raised for the first time on appeal. [Record p. 127, 147-148]

The Court thereafter ordered the parties to file briefs informing them that the decision would be made based upon the briefs and the transcript of the hearing before the committee. Based thereon, the District Court affirmed the revocation of the Plaintiff's license.

ARGUMENT

POINT I

THE OSTEOPATHIC COMMITTEE WAS NEVER DULY CONSTITUTED AND THEREFORE LACKED JURISDICTION TO ACT

Under the laws of the State of Utah, the Department of Registration is a duly recognized administrative "agency" as defined in Utah Code Annotated 1953 §63-46-3(1), authorized to adjudicate, and grant or withhold licenses. It is basic law

that as a creature of statute this agency has only such power as is specifically defined by the statutes granting the Department licensing or revocation powers, and Courts will not interfere with the decisions of an administrative tribunal unless it appears that it acted in excess of its powers. See Central Bank and Trust v. Brimhall, 28 Utah 2d 14, 497 P2d 638 (1972)

The Utah Supreme Court has made clear that in proceedings before an administrative tribunal it is requisite primarily that a party must be given the opportunity to have notice, an opportunity to be heard and defend, in an orderly proceeding adapted to the nature of the case, before a tribunal having jurisdiction of the cause. See Empire Electric Assn. v. Public Service Comm. 604 P2d 930 (Utah 1979)

The Osteopathic Committee is authorized under the provisions of Utah Code Annotated 1953 § 58-1-5 which provides as follows:

> The functions of the Department of Registration shall be exercised by the director of registration under the supervision of the commission of the Department of Business Regulations, and when so provided, with the collaboration and assistance of representative committees of the several professions, trades and occupations as follows:
>
> (13) For osteopathic physicians and surgeons, a committee of THREE members each of whom shall be a graduate of a chartered college of osteopathy of recognized standing. (Emphasis added)

The qualifications of the THREE committee members is defined in Utah Code Annotated 1953 § 58-1-6 as follows:

> ...Each member of a committee MUST HAVE had a license to practice in this state for a period of FIVE YEARS immediatley prior to his

> appointment and be in good standing in the profession, trade or occupation for which appointed. ...
>
> ...each member SHALL HAVE been a resident for a period of three years, and shall be domciled within the State of Utah. [Emphasis added]

Dr. Katherine V. Greenwood, one of the three members of the osteopathic committee which heard the evidence and recommended the revocation, was disqualified and barred from acting as a committee member. Dr. Greenwood was licensed to practice in Utah on June 6, 1978 [Record p. 140] just 2 years and 7 months prior to her purported appointment to the committee on January 5, 1981. [Record p. 139] At the time of her application for licensing, on April 19, 1978, she was a resident of Bettendorf, Iowa. [Record p. 141]

The language of the statute creating the committee is mandatory language, which cannot be altered by the act of the director of registration, nor by a ruling of the District Court by calling her a de facto officer.

There is no provision in Utah Code Annotated 1953, Title 58 Chapter 1 for any other number in the committee but THREE, and unless the legislature provides otherwise, a committee of two qualified members and 1 disqualified Doctor does not constitute the statutory committee, and being an administrative tribunal can only be vested with the power as specifically granted by the act creating it. In re Whitmer, in and for Salt Lake County, 515 P2d 617, 30 Ut 2d 206 91973) Administrative agencies are creatures of statute and their power is totally dependent upon statutes, so they must find within the

statute, warrant for the exercise of any authority which they claim.

The general law regarding the effect of the participation in the determination by one disqualified member is discussed in 1 American Jurisprudence § 69 p. 864 as follows:

> Participation in a determination by one disqualified member of a tribunal of three affects the action of the whole body. It is generally held that if a disqualified member of an administrative agency participates in the hearing and determination it makes the decision **void or voidable** at the instance of a party aggrieved who has made timely protest, even though his presence was not required to constitute a quorum, or a majority of the board could have acted legally without him.
>
> A determination made or participated in by a disqualified officer is merely voidable where only the common law rule as to disqualification is violated and proceeding is reviewable, but if participation by a disqualified officer is prohibited by statute, the determination is void! (Emphasis added)

See also Stahl v. Ringgold County, 187 Iowa 1342, 175 NW 772, 11 ALR 185, (1964) In re Weston Benefit Assessment Special Road District, 294 SW 2d 353 (Mo App 1956)

In this matter, the participation of the disqualified member is clearly prohibited by statute and accordingly their determination is void, and jurisdiction never vested in the committee.

POINT II

REVOCATION OF APPELLANTS LICENSE BY THE PURPORTED COMMITTEE CONSTITUTED A DENIAL OF DUE PROCESS OF LAW

Although the Supreme Court of Utah has made clear that

the granting of a professional license is a privilege under Utah Code Annotated 1953 § 58-1-1.1 or § 58-12-27, and as emunicated in State v. Hoffman, 558 P2d 602 (Utah 1976), nevertheless the Courts have uniformly held, that once the license is granted, it is a "property right" in the sense that a Board may not deprive the holder of the license, without satisfying the requirements of "due process". See Cross v. Colorado State Board of Dental Examiners, 552 P2d 38, 37 Colo App. 504 (1966); State Board of Registration for Professional Engineers v. Antonio, 409 P2d 505, 159 Colo 51 (1965). The Supreme Court of Utah has recognized that a license is entitled to the safeguards of due process. See: Athay v. State Department of Business Regulations, 626 P2d 965 (Utah 1981); In re Gudmundson, 556 P2d 212 (Utah 1976).

This Court has made clear that the essentials of due process are

> "1) the existence of an appropriate tribunal 2) inquiry into the merits of the question presented; 3) notice of the purpose of the inquiry; 4) opportunity to appear in person or by counsel; 5) fair opportunity to be heard; and 6) judgment rendered in the record thus made." State of Utah in re LGW; Utah Supreme Court, Dec No. 17689 (Nov. 3, 1981)

See also Cuddy v. State Department of Public Asst., 442 P2d 617, 74 Wash 2d 17 (1969); Dodds v. Ward 418 P2d 629 (Okla 1966)

In spite of those safeguards, the Plaintiff herein was judged by a committee which was not authorized under the laws of Utah and to allow the deprivation of his license to practice medicine, to be accomplished by that committee in violation of

Title 58 safeguards, is a denial of due process under the constitution.

It is not enough to reason that the remaining two memebers voted for the revocation and they constitute a majority of the committee. In the case of Board of Medical Examiners v. Steward, 102 A 2d 248 (Ct. of app MD 1954), a Doctors license revocation was reversed because the three member medical board was improperly constituted, a substitute, without statutory authority, having been appointed. There the attorney general argued that since a majority could revoke and the vote was unanimous, the law was gratified. The Circuit Court ruled that the Doctor was entitled to a fair and impartial hearing before a legally constituted board and the board was not legally constituted when it heard the complaint.

Participation of the disqualified member would obviously taint the decision of the board. Dr. Greenwood was not a passive member of the board. She became an active interrogator on the board, even making her own statements of what the medical standards of the profession consist of. [Record p. p. 833-837 and 1094-1109] There is no way one could conclude by examining the record, that the decision was not tainted by this disqualified Doctor's participation therein.

POINT III

THE COMMITTEE FAILED TO ESTABLISH ANY STANDARDS OF CONDUCT AS REQUIRED BY STATUTE

The committee further failed to publish any standards

to give notice to the Plaintiff as to what conduct is prohibited. Utah Code Annotated 1953 § 58-1-13 provides:

> "The following functions and duties shall be exercised or performed by the department of registration, but only upon the action and report in writing of the appropriate representative committee:
> ...(6) Defining unprofessional conduct, except as herein otherwise provided
> (7) Promulgating and enforcing such rules and regulations as may be advocated yb the representative committee of the several professions, trades and occupations for the protection or best interest of the public..."

Neither the Osteopathic Committee nor the department of registration have at any time published any standards of conduct for osteopaths. At the conclusion of the hearing, the committee made the following finding: [Record p. 170]

> 1. We find that osteopathic physicians and surgeons should maintain and uphold the same standards of care as medical doctors in caring for and treating their patients. When a physician assumes primary care of a patient by advising a patient to discontinue medications or instructions from a previous physician, the new physician should do a complete physical examination and record such. The physical examination should include at least examination of heart, lungs and abdomen. No intravenous solutions should be given without a physical examination (including heart and lungs) being performed. We also find that a physician must be in attendance when intravenous solutions are given unless it is an emergency. We find that Robert B. Vance did not abide by and follow these standards in his treatment of patients and in particular in his care and treatment of James Nickeson.

These standards were never established by the committee prior to the hearing, and in fact most were statements given to the committee by Dr. Katherine Greenwood, the disqualified board member, during the hearing, [Record p.

833-837 and p. 1094-1109] as her opinion of medical standards without supporting testimony of medical witnesses.

The Idaho Supreme Court in the case of Tuma v. Board of Nursing, 593 P2d 711, 100 Ida 74 (1979) reversed the revocation of a professional license concluding that the board cannot suspend a license for unprofessional conduct by merely hearing evidence of licensee's conduct and then concluding that it was unprofessional, but that the board must first publish rules and regulations to warn the licensee of the prohibited conduct.

If the Department had even stated in the complaint, what standards of care the committee had established and the conduct Dr. Vance was being charged with as being "unprofessional", then in the presentation of his case, the Plaintiff could have known that he must present evidence regarding the giving of "physical exams", and "at least examination of the heart and lungs" as well as whether or not he was "in attendance when intravaneous solutions are given", and whether intravaneous solutions were given without a physical examination being performed. These violations of the standards of care were for the first time published and their violation charged against the Doctor in the committee's Findings of Fact; at the Conclusion of the hearing. [Record p. 170]

As the Court in Tuma, supra at p. 717 concluded:

> "It is important to note also that the void-for-vagueness doctrine is two-pronged. not only are those whose activities are proscribed entitled to definite standards by which they may be guided, but it is equally important that the standards are there to

> guide those officers or agencies required to pass judgment on licensees called to account for their conduct."

In Ex parte McNulty, 77 Cal. 164, 19 P. 237, 239 (1888), the Court expressed concern over the possibility that an individual might lose substantial rights "for the violation of any vague, undefined notion of unprofessional conduct which might, after the fact, be enteretained by certain individuals constituting a board of examiners." (Emphasis added.) To which must be added that the membership of the Committee is a changing thing, and as the Committee make-up changes, it cannot be said that notions of unprofessional conduct may not also change. There must be standards against which conduct can be uniformly judged by Courts and administrative agencies.

The Supreme Court of Arizona, in Arizona State Board of Medical Examiners v. Clark, 97 Ariz. 205, 214, 398 P. 2d 908, 915 (1965), stated as follows:

> "As applied in the licensing and revocation cases 'unprofessional conduct' has been construed to include serious offense, such as intentional violations of law or recognized professional standards. ..."
>
> "There must be a 'conscious and culpable act amounting to a willful design to do that which is denounced as a unlawful professional practice."

In Megdal v. Oregon State Board of Dental Examiners, 605 P. 2d 273, (Sup. Ct. Ore. 1980), the Supreme Court of Oregon similarly held, with respect to a dentist's license to practice dentistry, that the conduct of a dentist did not constitute a legal ground on which to revoke his license since the Board of Dental Examiners had made no rule to proscribe his conduct. The

Court further held that expert testimony is not the proper source for determining the governing standards of unprofessional conduct. A board may not proceed on the assumption that all members of the profession should be expected to share unarticulated understandings about professional manners and mores.

This latter factor is particularly true in light of the fact that the judgment of one physician might differ from that of another physician in respect to the course of treatment to be followed. Dickinson v. Mason, 423 P. 2d 663 (Sup. Ct. Utah 1967).

The lace of identifiable standards herein is fatal to the charge of unprofessional conduct, where, as here, the appropriate application of the modalities involved are subject to a lack of consensus among medical experts. In such a case, the competent physician is only bound to exercise his best judgment in determining what course of treatment is the best. 70 C.J.s., Physicians and Surgeons, Section 44, p. 953.

Even had the board, in this case, previously established the standards it announced in its findings at the hearing conclusion, it is clear from the record, that the evidence does not support their findings stated in paragraph 1 thereof:

> "We find that Robert B. Vance did not abide by and follow these standards in his treatment of patients. ..." [Record p. 170]

The record is clear that in case of the eight named complainants regarding whose treatment, the board made adverse findings, that Dr. Vance did in fact do a complete physical examination on seven of the eight patients and on the eighth-

James Nickeson, there is contradicting testimony.

In the case of Judith Sevcik, she testified [Record p. 687] that Dr. Vance, took her medical history, examined her heart, and a full physical was completed and written down, as verified by Exhibit R-4, including a complete blood survey analysis by Upjohn Laboratories.

In the case of Ileen Vigil she also testified that Dr. Vance did several tests on her when she first went to him in July 1971. [Record p. 468] The Departments Exhibit V shows that she also received a physical examination, and the results were clearly recorded as shown by Exhibits U, V, X, Y, Z and A.

In the case of Mary Katsenavis, she also testified the Doctor took her history and examined her [Record p. 221-225] and the examinations and various lab tests verified by Exhibit JJ.

In the case of Ruby Riddle, she testified that Dr. Vance gave her a "complete physical" including blood tests [Record p. 515], this also is verfied by Exhibits EE, FF and GG.

In the case of Lois Carter, she testified that she was treated by Dr. Vance after several years with Dr. Conklin in the same clinic. She testified of numerous exams and tests given her by Dr. Vance. [Record p. 250-255]

The patient Jan Stevens also testified that on her first visit she received a physical exam including height, weight, blood pressure, pulse, medical history and glucose tolerance test [Record p. 436-437] and verfied by Exhibits GG and KK.

In spite of the overwhelming evidence the committee erroneously concluded that "Robert B. Vance did not abide by and follow these standards in his treatment of patients." Their conclusion is arbitrary and capricious and unsupported by the preponderance of the evidence presented to the committee.

POINT IV

THE OSTEOPATHIC COMMITTEE FAILED TO IMPOSE THE PROPER EVIDENTIARY STANDARD, BASING ITS DECISION ON HEARSAY EVIDENCE AND ITS DECISION WAS ARBITRARY AND CAPRICIOUS

In hearings before this administrative tribunal, ie the Osteopathic Committee, the rules of evidence concerning the use of hearsay evidence were stated by the administrative law judge at the beginning of the hearing, as follows:

> "The rules here do specifically permit hearsay evidence but they also adopt what's called the residuim rule which means that hearsay evidence alone can't be used to substantiate a finding of fact." In other words there must be some competent evidence which corroborates the hearsay in order for the board to reach a finding." [Record p. 4]

Of all of the medical experts who were called by the Department, only one testified that Dr. Vances methods of techniques were unprofessional. That witness was Dr. Alan J. Concors, an osteopath who had practiced osteopathy for 15 years, all outside the State of Utah, except for the one month prior to the hearing during which time he had practiced in Utah, in Tooele County beginning December 1, 1980. [Record p. 799] Although Dr. Concors, had practiced only one month in Utah, he is in practice with no other osteopaths, and is not a member of

the Utah Association of Osteopathic Physicians, nevertheless, he was the sole medical witness who testified what the acceptable standard of care is in the State of Utah.

The Department's attorney asked [Record p. 820]:

> "Based on all the questions that I have asked you and the opinions that you have with regards to the practice of the respondent do you have any professional opinon as to whether this man is practicing within the confines of and the scope of osteopathic medicine as it is taught and as it should be practiced in the State of Utah under the requirements of professionalism and professional conduct?" [Emphasis added]

Dr. Concors answered [Record p. 821]

> "... I feel that this is unacceptable, It's unethical and it's --- at present I just think its totally unprofessional."

Nothing is reflected in the record to show that Dr. Concors has had any experience or teaching to qualify him with knowledge of the Standards as "taught" and "as it should be practiced" **IN THE STATE OF UTAH.**

Further Dr. Concors was allowed to testify hearsay testimony regarding Chelation Therapy, of the position of the one Dr. Ed Daring, Chairman of the Department of Ethics for Osteopathic Board of General Practitioners, over the objection of Plaintiff's counsel [Record p. 802], even though the examiner knew that Dr. Ed Daring would not be a witness and no corroboration would be given. Dr. Concors responded in the most inflamatory hearsay testimony, as follows:

> "Yes, that the position of the chairman of the Department of Ethics for the Osteopathic General Practitioners College, is that as far as he was concerned, and the majority

> of the profession is, that they would stand behind any denouncing of this type of treatment and management." [Record p. 802]

Again Dr. Concors, in regard to Chelation Therapy, after testifying:

> "As far as its treatment in the use of every day general practice, and especially on an out patient basis, I have just never read anywhere in the literture. I have never read any text on it. And I have never come across it in any medical journals, either DO or MD. I've never heard it discussed at any medical conventions. And I know for a fact that it's not taught at any medical schools or osteopathic medical schools." [Record p. 804]

Yet after admission of his lack of knowledge or expertise regarding Chelation Therapy, concluded that it's administration could be dangerous to the health of an individual. [Record p. 804 Line 11]

Contrary to Dr. Concor's biased and unqualified testimony, three eminently qualified physicians Dr. Halstead, Dr. Gordon and Dr. Gerber, testified as peers of the Plaintiff, that Dr. Vance's methodoligy and treatments were totally acceptable within the standards of practice, that Dr. Vance is highly qualified, a diplomate in the American Society of Medical Preventics which teaches and certifies the use of Chelation Therapy (as used by Dr. Vance) among several hundred Doctors, both MD and DO throughout the United States. [Record-Dr. Gordan p. 623; Dr. Halstead p. 1110-1174; Dr. Gerber p. 1007-1104]

POINT V

THE COMMITTEE'S DECISION IS NOT SUPPORTED BY A PREPONDERANCE OF THE EVIDENCE

The evidentiary standard has been clearly pronounced

by this Court in the case Withers v. Golding, 111 P2d 550, 100 Ut 179 (1941); at page 554:

> "...the Court should determine on an appeal in equity whether the findings of the committee are contrary to the **CLEAR PREPONDERANCE OF THE EVIDENCE**, before it rather than to determine merely whether there is any substantial evidence to support the findings."

After making general statements regarding the newly formed standards, the committee then made broad, findings and conlcusions without any corroborating, non-hearsay evidence. Paragraph 3 of the Findings, concludes that:

> "In as much as Chelation Therapy is not accepted among medical standards as a proper method of treatment for atherosclerosis in the United States, it should not be prescribed as such by a physician in general practice." [Record p. 170]

A. **CHELATION THERAPY**

Only one medical witness testified that Chelation Therapy was not acceptable among medical standards in the United States, and that was Dr. Concors, by his blatant hearsay statement. [Record p. 802 Line 17-22], totally uncorroborated by any other evidence.

As against the worthless testimony of Dr. Concors, experts testifying on behalf of Dr. Vance amply validated the value and use by many physicians throughout the United States of Chelation Therapy. One of these witnesses was Dr. Michael Gerber, a California Medical Doctor with impressive qualifications, including a pharmacology background, and serving on the Board of the prestigious Stanford Research Institute, among other things. [Record p. 1171] Dr. Gerber is on the Board of

American Academy of Medical Preventics, which has heretofore certified Dr. Vance as an expert, namely a diplomate, in Chelation Therapy. Dr. Gerber has practiced Chelation Therapy [Record p. 1171], and noted that the modality has been officially recognized by the State of California. [Record p. 1172] Dr. Gerber also described the rigid requirements of the American Academy of Medical Preventics to train a physician in the use of Chelation Therapy. [Record p. 1222] Dr. Gerber's testimony as to Chelation Therapy, summarized, would be that this is a very valuable modality.

Also testifying concerning Chelation Therapy was Dr. Garry Gordon, a California Osteopath and Medical Doctor, and co-author of a monograph published in a medical publication "Osteopathic Annals." [Record p. 1026] Dr. Gordon stated that Chelation Therapy for arteriosclerosis was started in approximately 1950, that improvement in circulation or improved blood flow is the objective. [Record 1027-1028] Dr. Gordon outlined the protocol for appropriate Chelation Therapy, as designated by the American Academy of Medical Preventics. Dr. Gordon indicated that there are approximately 3,000 scientific articles concerning EDTA, in the records of the American Academy, and that the toxicity of EDTA as used for Chelation Therapy is approximately the same as that for aspirin or Vitamin A. Dr. Gordon's testimony may be summarized as being in full endorsement of Chelation Therapy, and its value as a modality for physicians.

Not only was there expert testimony concerning the value of Chelation Therapy, but four actual patients of Dr. Vance testified as to the remarkable results they had obtained through this therapy.

Mr. Dean Baxter testified that he was an executive in the Houston area, that a doctor told him that open heart surgery was necessary or he would die before he left Utah, and that he was very sick. Baxter checked himself out of a hospital, went to a Utah Doctor who had scheduled him for open heart surgery the next day, but he went to Dr. Vance, received Chelation Therapy in 1977, and that he is completely recovered, with later checkups showing no problems. [Record p. 1325]

Maurice Yates related the various doctors that he had been treated by, and that three doctors, whom he named, desired to cut his leg off, and that he had two artery transplants, one in each leg. His left leg failed. Subsequently Yates had Chelation Therapy (40 treatments), and still has his leg. [Record p. 1112]

Benjamin Cristensen, vice president of a local Bank, became a patient of Dr. Vance in March 1979, having been previously under the care of an internist. He could not walk more than one or two blocks without chest pains, subsequently took 30 Chelation Therapy treatments from Dr. Vance, until September 1979. He testified that he can now walk 5 to 7 miles without pain, even hikes in the mountains, snowmobiles, and takes no nitroglycerin. [Record 1124-1127]

Willard Porter was a patient of Dr. Vance in 1975 or 1976, now being 81 years of age. Previously he had been under the care of 2 or 3 Doctors, had chest pains, shortness of breath, and other symptoms. Prior to seeing Dr. Vance for treatment he had been so weak he could not stand up, could not sleep, and had given up hope. Porter took 20 Chelation Treatments, also being put on a strict diet, and feels hale and hearty and is very active, entertaining school children with a musical novelty act, playing on a musical saw, also playing the harmonica with his nose, and enjoys life very much. [Record p. 1129] Following Mr. Porter's testimony, Osteopathic Doctor Hase said "Congratulations, Sir."

Such a situation as is involved herein was involved in the matter of Rogers v. State Board of Medical Examiners of Florida, District Court of Appeals, First District, State of Florida, January term, 1979, Case No. EE-454 (date of opinion, January 9, 1979), 371 So. 2nd 1037, Certiorari denied by Florida Supreme Court, September 17, 1979 (376 So. 2d 76).

Dr. Robert J. Rogers has practiced medicine in Brevard County, Florida, treating various of his patients with Chelation Therapy, for arteriosclerosis and other circulatory diseases. The Brevard County Medical Association entered an Order causing the suspension of his license to practice and threatened expulsion from the Association, and imposing other punishment, as well. The question on appeal as posed by the Court was stated:

> "... to what extent does the State of Florida have constitutional authority to

> prohibit a non-harmful mode of medical treatment by a licensed physician after full disclosure to, and election by, a patient?"

The Court noted in its Opinion that Dr. Rogers had engaged in use of Chelation Therapy for treatment of arteriosclerosis, which procedure had not been authorized by the Florida State Board of Medical Examiners. The Court also defined "Chelation Therapy" in terms analogous to the therapy used by Dr. Vance herein. The Court also stated that the Florida Legislature had a right to prescribe reasonable rules and regulations to control practice of medicine, and that such regulations must bear a reasonable relationship to the general welfare of the public. The Court noted, however:

> "... in that regard it is relevant to note that neither BCMA, the hearing officer,nor the Board has made any findings that Chelation Therapy is in any respect harmful or hazardous to the patient. Rather, the Board's decision appears to have been based upon the Hearing Officer's administrative determination that Chelation Therapy is a 'quackery under the guise of scientific medicine..."

The Court's opinon was then addressed to the right of privacy of both physician and patient, the Court affirming that the right to make a private decision as between patient and attending physician is one well-recognized. The opinon further states:

> "... We hold that under the provision of the Constitution, in the absence of a demonstration of unlawfulness, harm, fraud, coercion or misrepresentation, respondent Board is without authority to deprive Petitioner's patients of their voluntary election to receive Chelation Therapy simply because that mode of treatment has not received the endorsement of a majority of the medical pro-

fession. It necessarily follows that under such circumstances Respondent Board is without authority to prohibit petitioner from administering Chelation Therapy.

"History teaches us that virtually all progress in science and medicine has been accomplished as the result of the courageous efforts of those members of the profession willing to pursue their theories in the face of tremendous odds despite the criticisms of fellow practitioners. Copernicus was thought to be a heretic when he theorized that the Earth was not the center of the Universe. Banishment and prison was the reward for discovering that the World was round. Pasteur was ridiculed for his theory that unseen organisms caused infections. Freud met only resistance and derision in pioneering the field of psychiatry. In our own era chiropractic treatment has been slow in receiving the approval of the other professions of the healing arts. We can only wonder what would have been the condition of the World today in the field of medicine in particular had those in the midstream of their profession been permitted to prohibit continued treatment and thereby impede progress in those and other fields of science and the healing arts..."

The record herein is devoid of any probative or competent evidence justifying the criticisms of the Osteopathic Committee of Chelation Therapy, and it is further most evident that at no time has the Osteopathic Committee of Utah ever adopted any standards, or regulations whereby a physician could deem that employing Chelation Therapy would be "unprofessional conduct".

B. LAETRILE

The Osteopathic Committee also undertook to attack Laetrile in their findings as follows:

"We find that Laetrile (Amygdalin, B-17) should not be prescribed in lieu of standard accepted medical treatment for a patient suffering from cancer."

As previously noted, at no time was there any designation herein as to what would constitute "standard accepted medical treatment" for cancer patients. And, once again, the Utah Osteopathic Committee had not before issuing its decision adopted any standards whatsoever which would proscribe use of Laetrile by a physician exercising his best judgment and discretion as to the welfare of his patient.

As to Laetrile, its safety and efficacy, and usefulness as to various types of cancer cases, expert testimony by Dr. Bruce Halstead, California Medical Doctor, Clinician, and Biotoxicologist was most comprehensive, and which stands unrefuted and undenied herein. [Record 1270-1334] Also, one Alice Pearson, a patient of Dr. Vance, suffering from the most serious type of cancer, namely multiple myeloma, testified that she had been receiving Laetrile up until the time she testified, that a previous Doctor stated she would have fractures over her body. However, she stated that, at 67, she now feels very well, does all her own yardwork and gardening, contrary to her terrible condition before seeing Dr. Vance. She further stated that her pain started leaving almost immediately after Laetrile injections were commenced, with no side effects whatsoever. (Tr. 962-966)

There is nothing whatsoever illegal or improper about utilization of Laetrile by a physician. Thus far, 24 states have specifically sanctioned use of Laetrile by special legislation (Arizona, Delaware, Florida, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Nevada, New Hampshire, New

Jersey, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Washington, Montana, Colorado, Kentucky, West Virginia, and California). Concerning the propriety of use of Laetrile at the Federal level, the same has been validated and approved as recently as May 1, 1981, by decision of the U.S. District Court for the Western District of Oklahoma in the case of Rutherford et al v. United States of America, Joseph Califano, Secretary of Health, Education and Welfare; Donald Kennedy, Commissioner of the Food and Drug Administration, et al. Findings of Fact and Conclusions of Law in Cause No. CIV-75-0218-B, an unreported decision, [Record p. 241-248].

The findings of the Osteopathic Committee as to Laetrile were clearly erroneous, improper and arbitrary and capricious.

c. In the case of each of the eight persons who were subjects of findings by the Osteopathic Committee, Dr. Vance was charged with some sort of professional misconduct purportedly warranting revocation of his osteopathic license. Upon a review of each case, the transcript is replete with innuendo, new charges which were not in the original petition and complaint and therefore irrelevant to the actual charges of the petition, voluminous amounts of hearsay evidence, attacks by the Prosecutor on medical modalities which properly should be considered only as differences of medical opinion which occur between physicians. What follows is a review, in the light of the charges, to demonstrate the paucity, even total lack, of proper and competent evidence, to warrant the findings of the osteopaths below.

1. Lois Carter (Petition, Charge 7I) The charge of the petition was:

> "I. Prior to December 1975, Robert B. Vance did for a period of approximately six years treat Lois Carter for hypoglycemia which he told her she had; that the laboratory tests on said Lois Carter did not indicate her having hypoglycemia; that Robert B. Vance provided other treatment consisting of wet pads placed under each shoulder blade, behind each ear and a pad with a strap across the forehead at which time Lois Carter was hooked or connected to a machine which, according to the attendants of Robert B. Vance, was used for the relaxation of the adrenal gland. The treatment for hypoglycemia was for a non-existent condition and Robert B. Vance knew or should have known it did not exist and the treatment with the wet pads and machine for the purpose of relaxing the adrenal gland was not then and is not now an accepted medical procedure by the standards of his profession and amounts to gross incompetency in the practice of osteopathy." [Record p. 176]

The findings of the osteopaths below were:

> "I. We find the allegations to be substantially supported by the evidence." [Record p. 170]

The petition herein reached back to 1969, or approximately 11 years before the hearings herein took place, for charges against Plaintiff concerning Lois Carter. In and of itself, such action must necessarily be considered unjust, unfair, and no doubt illegal, due to the tremendous lapse of time which intervened between the period of treatment involved and the time of the hearings.

In any event, the record herein is devoid of any proper evidence to warrant the findings.

Relative to the "wet pads and machine" portion of the charges, no evidence whatsoever was adduced by Lois Carter.

Concerning the serious charge that Lois Carter never had hypoglycemia, the record contains no evidence whatsoever. It was Lois Carter's testimony [Record 586] that she had gone to a Doctor other than Dr. Vance and had a hypoglycemia test, which was negative. This hearsay testimony was corroberated by Dr. William Pace, a psychiatrist who had treated Lois Carter from time to time. He testified [Record 930] that he obtained a glucose tolerance test for Lois Carter in April 1977 which was negative for hypoglycemia [Record 931]. This was almost two years after Dr. Vance last treated her, and about 8 years after Dr. Vance commenced his treatments.

If anything, the 1977 test only demonstrates that Dr. Vance was successful in eliminating any hypoglycemic condition he observed in 1969, and by treating her during the six years ensuing. Dr. Pace himself testified that hypoglycemia is treatable and can be brought back within normal limits [Record 936].

There was no basis at all for the osteopaths to find Dr. Vance guilty of "gross incompetence in the practice of osteopathy" concerning his treatment of Lois Carter.

2. Ruby Riddle (Petition, Charge 7H) In this instance, the petition reached back approximately ten years before the hearings took place. The charge was:

> "H. Robert B. Vance undertook to treat and did treat Ruby Riddle, beginning on November 2, 1970, for 'relative hypoglycemia secondary to chronic subclinical adrenal

cortex hypofunction'; that thereafter Robert B. Vance treated said Ruby Riddle for arteriosclorosis, using a procedure Called Chelation Therapy; that he also used a procedure called myoflex; that the clinical history and laboratory tests and said patient did not indicate a condition known as hypoglycemia and the use of Chelation Therapy to treat arteriosclerosis by removal of calcium in the body is not a medically accepted method or procedure and can result in harm or death to a patient." [Record p. 176]

The findings were:

"H. We find the allegations to be true. He charged for a Cronogram (Kirlian Photography) which he testified he was doing for research purposes, without notifying the patient of such fact and admitted its use as a diagnostic tool was of questionable value."

The findings concerning Ruby Riddle were premised solely upon her hearsay testimony relating to her treatment by Dr. Vance 7 to 10 years prior to the time of the hearings. There was no medical testimony concerning her. The record is devoid of any evidence relative to the charge that she never had hypoglycemia.

Likewise, the record is devoid of any evidence that Dr. Vance's judgment to render Chelation Therapy for Ruby Riddle was improper. Whether or not Chelation Therapy would be "medically accepted" by the Prosecution certainly cannot constitute a basis for concluding Dr. Vance to be guilty of professional misconduct. The record herein shows that many physicians throughout the United States, including osteopaths, employ Chelation Therapy as a useful modality for their patients, and the record herein further reveals it to be an effective modality in many cases.

The findings concerning Ruby Riddle gratuitously injected new matter not the subject of any charge, namely a "Cronogram" [Record p. 171] (sic) allegedly taken by Dr. Vance. It is respectfully submitted that this purported "finding" should from no "ex. post facto" basis for validation of the charges against Dr. Vance in the Petition herein.

3. Milo Adams (Petition, charge 7R) Reaching back for a period of about 7 years, the charge was:

> "R. Robert B. Vance undertook to treat a patient by the name of Milo J. Adams beginning on or about August 4th, 1973 on the basis of his following diagnosis: 'Hypokalemia; hypochlorhdria; latent diabetes mellitus; diabetogenic and reactive hypoglycemia; subclinical hypoadrenocorticism, arterio scleritic heart disease."
>
> Robert B. Vance treated said patient through to September 26, 1973 for the foregoing-stated conditions. The laboratory tests and clinical examination did not indicate said patient was suffering from any or all of the foregoing conditions. Robert B. Vance knew or should have known he was treating said patient for non-existent health problems, maladies and dysfunctions and his conduct therein amounts to gross incompetency in the practice of osteopathy." [Record p. 179]

The findings were:

> "R. We find the allegations to be substantially supported by the evidence.

As will be noted, the charges concerning Milo Adams accuse Dr. Vance of "gross incompetency" based upon his alleged treatment of "non-existent health problems, maladies, and dysfunctions". For five of these conditions, namely "Hypokalemia" (sic), "hypochlorhdria" (sic), latent diabetes mellitus", "subclinical lypoadrenocorticism", and "arterio

scleritic heart disease" no evidence whatsoever was introduced in support of the charges.

Relative to the alleged non-existence of any hypoglycemia condition, no evidence was presented as to the propriety of Dr. Vance's original diagnosis. Only the testimony of one Dr. Allen Barker was offered [Record p. 841] relative to a glucose tolerance test which he had ordered for Adams. Dr. Barker said the test was "essentially normal" [Record p. 844], but even he noted a four-hour low sugar value [Record p. 845], further conceding that a side effect of the drug, "Aventyl", which had been administered to Adams, could show "fluctuation of blood sugar levels". [Record p. 856]

However, this test had been performed in December, 1973, some four months after Dr. Vance had commenced his treatment of Adams.

Under these circumstances the only probative value of Dr. Barker's testimony was to substantiate Dr. Vance's success in eliminating any condition of hypoglycemia, not to support a charge of "gross incompetency".

4. Ileen Vigil (Petition, Charge 7E) The charge reaching back for a period of about 9 years, was:

> "E. On or about the 29th day of July, 1971, and for several years thereafter Robert B. Vance did undertake to diagnose and treat Ileen J. Vigil; that in such treatments his records reveal that he used a method of treatment which is not medically accepted and proved; that he failed to properly diagnose the medical problems of said Ileen J. Vigil and furthermore failed to understand the diseases he purported to diagnose and treat with regard to his patient." [Record p. 175]

The findings were:

"E. We find the allegation to be true and substantially supported by the evidence."

As to the "shotgun" charge that Dr. Vance used "a method of treatment which is not medically accepted and proved", no evidence whatsoever was introduced concerning what such treatment might be, let alone its "acceptability".

Nor was any evidence whatsoever introduced that Dr. Vance had "failed" to properly diagnose Ileen Vigil's medical problems, or that he "failed to understand the diseases he purported to diagnose and treat".

5. James Nickeson (Petition, Charge 7II) In this instance Dr. Vance undertook unsuccessfully, to help a terminal cancer patient.

Basically the charge was that at the end of December 1978, Dr. Vance consulted by telephone with the mother of James Nickeson, and was advised that her son was suffering from Ewings Sarcoma, a type of terminal bone cancer, that he assured the mother that much could be done for her son, that if she could get James Nickeson to Salt Lake City Dr. Vance could save him. The charges further state the on January 5, 1979, James Nickeson was carried on a stretcher into the office of Dr. Vance, where he was immediately administered an I.V. injection containing vitamins and laetrile. It was further charged that no examination was given or that any tests of any kind had been taken prior thereto. It was further charged that Dr. Vance instructed Mr. and Mrs. Nickeson to take their son to a motel

where he would send his nurse each day to administer I.V. injections and that the nurse would instruct the parents as to items needed for such medication.

It was further alleged that a urine sample was taken to be sent to a laboratory in Seattle, Washington, from which a serum could be made for treatment of the patient. Additionally, it was alleged that Dr. Vance took a blood sample, for another laboratory, the results of which would be informative. It was further alleged that although Mr. and Mrs. Nickeson requested results of the tests, they had received no response from Dr. Vance. It was further charged that during the entire time from the day when Nickeson was in the office of Dr. Vance, initially, and during the time he stayed at a local hotel facility for ten days, namely until January 16, 1979, not once did Dr. Vance attend him, leaving all such matters in the hands of his nurse, who daily administered the I.V. solution. It was alleged that the I.V. injections consisted of one-half bottle of glucose, some Vitamin C and liquid "Laetrile". It was further alleged that on January 16, 1979 the patient was flown back to Casper, Wyoming, passing away on January 26, 1979. It was further charged that the parents relied upon the representations of Dr. Vance that he could save their son, and consequently expended substantial sums, and that the patient suffered greatly from the administration of the I.V. injections and other medications.

The three osteopaths below found that there was evidence of "gross negligence" on the part of Dr. Vance, that the diagnostic process had not been completed, that he

instituted intravenous therapy before doing a physical examination, and in fact never did a physical examination, that the patient was treated with "questionable therapy" in lieu of "standard medical treatment", that he improperly discontinued "Coumadin Therapy", that in spite of the fact that Dr. Vance had gained a great deal of knowledge in the field of preventative medicine, assuming primary care for the patient was beyond the scope of his additional knowledge.

The aforesaid findings were almost completely predicated upon the testimony of Betty Nickeson, grieving mother of the terminal cancer patient, James Nickeson. It is obvious from a review of her testimony that she was embittered and hostile, not only as to Dr. Vance, but as to any other Doctors who had rendered treatment for her son. [Record p. 446] According to her somewhat incredible testimony, a Wyoming doctor had discovered that her son had bone cancer, that Doctor knew nothing about tumors and could do nothing for him, and she had lost confidence in him, he having supposedly operated through a tumor, placing a cast over it, and subsequently simply just walking out on his patient, while not referring the family to anybody for further treatment. [Record p. 446] It is respectfully submitted that this testimony by Mrs. Nickeson against a physician not even a party to this proceeding must be taken with some doubts, and also is illustrative of her almost hysterical animus against Doctors, including Dr. Vance, who had treated her deceased son.

Mrs. Nickeson's most extreme and questionable statement concerning Dr. Vance was that he, in effect, had promised to "cure" the incurable cancer with which her son was afflicted. As against this, Dr. Vance testified repeatedly that never at any time had he promised he would render a cure for James Nickeson, For example, Dr. Vance testified [Record p. 991]:

> "I've heard what Mrs. Betty Nickeson has testified and there are some things at which I am in gross and marked disagreement with her. No I, never at any time did I ever promise that I would render a cure for her son. In fact, I have taught my nurses and I've written it down many, many times in patients' charts which can be documented, that the best we can hope for in medicine is a control; that in fact the physician doesn't cure anything. Some physicians may think they do. But the best we can affect is to help the body through the intelligent application of the knoweldge we have at hand to achieve a therapeutic control."

Mrs. Nickeson's statements in this regard must also be considered against what were notable instances of false statements she made as to Dr. Vance's actual treatment for James Nickeson.

For example, Mrs. Nickeson stated [Record p. 355]: "In the entire time we were here - 10 or 11 days - he never examined him once and never directly talked to that boy one time." As against this sweeping statement was the testimony of Kathleen Berry, a Licensed Practical Nurse, and General Nurse for Dr. Vance, who had stayed specially on a Friday at Dr. Vance's office, when James Nickeson had been initially in the Vance offices and clinic. She testified that he arrived on a

stretcher, was placed on a table, and that Dr. Vance talked at length to him and his parents. [Record p. 954-955] Dr. Vance noted that this inital visit and consultation lasted a minimum of 4 hours with the patient and his family. [Record p. 1005] Nurse Berry further testified that on this initial consultation, she was asked to draw a blood sample, that he wrote orderes, a hair analysis test was ordered and I.V. injections were made. The family had brought hospital records and x-rays. [Record p. 956-957] Even according to Mrs. Nickeson, Dr. Vance had previously requested all available records and x-rays and that these records were given to Dr.Vance after they arrived. [Record p. 354-355]

Various of these records are in evidence herein, for example, Exhibit PPP, and which are voluminous, additionally including additional tests and medical information gathered by Dr. Vance. In this connection, Dr. Vance testified that he knew what the medical problem was already, having reviewed the medical records from Wyoming, and having himself submitted additional blood samples for a special test from a Michigan laboratory. [Record p. 1071] In view of these circumstances, why would it have been necessary for Dr. Vance to render a physical examination of Nickeson, when his condition was already known and verified? The record was already clear that Nickeson had sustained a broken back and a broken leg as a result of a work accident, compounded by terminal condition of cancer, Ewings Sarcoma. The Wyoming physicians had told Nickeson his time was very short. [Record p. 440]

Subsequently (contrary to Mrs. Nickeson's false testimony) Dr. Vance rendered physical examinations of his patient. [Record p. 1005,1071]

Nurse Berry testified that the Nickeson family desired to have James Nickeson in a Salt Lake City motel facility, rather than a standardized medical facility because it would be cheaper, and that the family wanted to do as much of the nursing care as possible. [Record p. 962] This was confirmed by Dr. Vance, who testified that he desired to minimize costs, that it made the circumstances more cost effective for the Nickesons to be in a motel environment where the family could render care which was needed. Dr. Vance also testified that no service which was to be rendered could be rendered better in a hospital than under the circumstances at hand. [Record p.998-999] This facts stand unrefuted and undenied herein.

Mrs. Nickeson testified [Record p. 357] that she told Dr. Vance: "We can't put that boy every day hauling him down the stairs for an I.V."

Accordingly Nurse Berry was delegated by Dr. Vance to visit Nickeson, administer I.V. injections and to help regarding nursing and in any other way possible. [Record p. 958] Nurse Berry stated that the Nickeson family called her at her home often. They also had Dr. Vance's home telephone, and if she could not answer questions, she referred them to Dr. Vance. [Record p. 964] Dr. Vance testified that he was in contact constantly with his nurse staff concerning the Nickeson case, and periodically visited Nickeson to ascertain his condition. [Record p. 947-1001]

The circumstances herein also demonstrate that, even as to what ultimately proved to be a hopeless case, Dr. Vance made every effort to help his patient. He testified in this regard that treatment in a similar case in Arizona had proved beneficial. [Record p. 994] Nurse Berry testified that on January 8, 1979, Nickeson's headaches stopped, his temperature broke, he woke up hungry, with less pain, and his color and alertness had improved. [Record p. 961] She further testified that during the 10 days Nickeson was in the City, some days he seemed better, and others not, but his color seemed improved, he seemed to be alert, he was more talkative and didn't seem to have as much pain.

However, in retrospect he did not recover from his terminal condition. Certainly this is not grounds for revocation of Dr. Vance's professional license. If so, any physician who was unsuccessful in treating a patient would lose his license, and then there would be no physicians left in the United States, because no Doctor is 100% successful in his treatment.

The Osteopathic Committee complained that Dr. Vance did not use "standard medical therapy" for James Nickeson's cancer. However, the record is not only devoid of any evidence as to what a "successful standard medical therapy" might have been for a patient diagnosed as terminal and having only a short time to live, but how it would have reversed a terminal condition. Dr. Vance did, under these circumstances, sanction use of "Laetrile" for Nickeson, and which has been efficacious in many difficult cancer cases.

If one were to accept Mrs. Nickeson's testimony herein at fact value, it could only be concluded that she and her family were bitterely dissatisfied about the treatment of their son by Dr. Vance. But they were not. Nurse Berry testified that no complaints of dissatisfaction were made to her while the Nickesons were in Salt Lake City,and that before they left the Nickesons took her to dinner "in appreciation" for all they felt she had done for their son. [Record p. 967] Dr. Vance testified that there had been no problems whatsoever with the Nickesons during their stay in Salt Lake City. [Record p. 998] And, after the Nickesons returned to Wyoming, Mrs. Nickeson wrote a letter, which comprises a portion of Exhibit PPP herein, dated January 19, 1979, addressed to "Hi Everyone", reporting in friendly tone what was transpiring in Wyoming, and terminating with "Hi, Kathy!"

6. Mary Katsenevas (Petition, Charge 7G) The charge, as relating to this person who was not a bona fide patient, was:

> "G. On or about the 17th day of September, 1979, Robert B. Vance undertook to and did treat Mary Katsenevas for a condition he called 'Diabetogenic Hypoglycemia' when in fact the results of her glucose tolerance test showed her to be within normal limits; that diagnosing and patient as being in the 'latent diabetic zone' and as having 'Reactive Hypoglycemia' and thereafter treating her accordingly, is false and misleading and contrary to the acceptable standards of practice."

The findings were:

> "G. We find the allegations to be true in that the evidence showed that Robert B. Vance did not do a physical examination; he used iridology, an unaccepted and unproven methods of diagnosis, and diagnosed

> hypothyroidism from a low axillary temperature with disregard for normal laboratory tests." [Record p. 171]

Dr. Vance performed a glucose tolerance test for Mary Katsenevas, concluding that she had "Reactive Hypoglycemia". (See Exhibit I)

To ostensibly support the charges that Mary Katsenevas did not have hypoglycemia the prosecution introduced testimony of two Doctors. However, on direct examination Dr. L. Wayland MacFarlane denied that he had performed a glucose tolerance test for her, that only a single "blood sugar" test having been taken March 30, 1977, concerning which he did not make any determination concerning a condition of hypoglycemia. [Record p. 654]

Mary Katsenevas had also been referred by the Attorney General to Dr. Robert K. Maddock, who examined her on February 11, 1980. He testified that she was depressed, and not very well when he saw her. [Record p. 494-496] Dr. Maddock testified that he diagnosed Mary Katsenevas as having a form of reactive hypoglycemia, alimentary-type [Record p. 423] He also stated that he would put this type of patient on a diabetic diet to control carbohydrate intake. [Record p. 399]

Thus, far from supporting the charges against Dr. Vance that Mary Katsenevas did not have a condition of hypoglycemia, Dr. Maddock in fact precisely confirmed Dr. Vance's diagnosis.

As if recognizing that the charges concerning Mary Katsenevas were baseless, the Osteopathic Committee below

"found" the charges to be true "in that the evidence showed that Robert B. Vance did not do a physical examination". Why a physical examination would be necessary to investigate for hypoglycemia is not explained any where in the record herein. And, Dr. Vance testified at some length concerning the nature of his examinations. [Record p. 921] The Osteopathic Committee also found fault with the manner in which Dr. Vance had diagnosed hypothyroidism. It is worthy of note that Mary Katsenevas had actually been under treatment several years for thyroid problems before she went to Dr. Vance. [Record p. 571]

Lastly, the osteopaths criticized Dr. Vance's use on occasion of Iridology, stating it to be "unaccepted and unproven". Yet their own witness, Dr. Concors verified the validity of diagnosing arteriosclerosis by examining the eyes. [Record p. 805] No other evidence was introduced against the use of iridology, however Dr. Gerber, gave unrefuted testimony that iridology is a form of diagnosis widely used around the world. [Record p. 1178]

These new and irrelevant "findings", which serve to obscure the fact that no evidence whatsoever supported the actual charges against Dr. Vance, should certainly form no basis for upholding a revocation of Dr. Vance's professional license.

7. Judith Sevcik (Petition, Charge 7A) This employee of a TV station was also a false patient. The charges were:

> "A. On or about the 6th day of April, 1978, Robert B. Vance did undertake to treat Judith Sevcik on the basis of his diagnosis dated April 19, 1978, that Robert B. Vance, furthermore, recommended and did thereafter provide inappropriate treatment for

> nonexistent diseases in said Judith Sevcik; that the treatment for arteriosclerosis, which condition did not exist in said patient, was called "Chelation Therapy", a medical procedure not acceptable in the medical practice and the use of which can cause a danger to the health, welfare or safety of a patient.:
>
> The findings were:
>
> "A. We find the allegations to be true in that Robert B. Vance provided necessary and unproven medical treatment for atherosclerosis by giving Chelation Therapy."

Judith Sevcik went to Dr. Vance for approximately one year in an attempt to gather something against him. To mislead the Doctor, she lied about her symptoms, and gave an inaccurate history. [Record p. 729] Any vitamin or other medications were not taken by her, but simply turned over to her TV station employer. [Tr. 710] She concealed from Dr. Vance that she had an enlarged ovary problem. [Record 719] She did not tell Dr. Vance about her mid-systolic heart click syndrome. [Record 729]

Judith Sevcik solicited Dr. Vance for Chelation Therapy treatments. [Record 721] She stated:

> "I continued about a year. And the main purpose was for Dr. Vance -- for us to get Dr. Vance to put me on the Chelation treatments. We didn't really think it would take a whole year, but it was from October to October, I think. And I took two Chelation treatments at the time that I quit seeing him."

Dr. Maddock testified as to physical examinations of Judith Sevcik performed approximately one year before she finally was able to obtain Chelation Therapy treatments from Dr. Vance. Based upon his examination and test, very limited in

nature, Dr. Maddock concluded that in October 1977 he made no physical findings indicating cardiovascular disease. However, when asked about Chelation Therapy, subject of the charges concerning Judith Sevcik, he stated that he knew very little about it, and that it would be best "not to pursue that question." Meanwhile, Dr. Maddock testified herein that "from the time we start breathing by ourselves, we start gathering calcification in the arteries around the heart and our lower extremities." [Record 419] He also testified that "short of an autopsy, it's pretty difficult to determine the extent of the arterial calcification." [Record p. 420] As disclosed by experts in Chelation Therapy who testified herein for Dr. Vance, a primary purpose of Chelation Therapy is to remove calcium deposits which build up in the arteries. However, Dr. Maddock offered no testimony in this regard, being ignorant of what Chelation Therapy involved. Nor did his testimony in any manner support a charge that rendering of two Chelation Therapy treatments for Judith Sevcik, based upon her false symptoms, history, and concealment of her physical condition, after requesting the same for approximately one year, constituted professional misconduct on the part of Dr. Vance.

8. Jan Stevens (Petition, Charge 7HH) this was another false patient who presented false symptoms, history, and information to Dr. Vance in an attempt to create charges against him. The charges were:

> "HH. Robert B. Vance on April 2, 1980 undertook treatment of a patient by the name of Jan Stevens on the basis of his following diagnosis: 'Reactive Hypoglycemia; Subclini-

cal Hypoadrenocorticism; Hyporproteinemia; multiple mineral deficiencies and imbalances; chronic acne trugaris and reaction syndrome food."

Robert B. Vance treated said patient through to May 21, 1980 for some or all of the foregoing conditions. The laboratory tests and clinical examinations did not indicate said patient was suffering from all or any of said diagnosed conditions and he knew or should have known he was treating and charging for treatment of non-existent health problems, maladies and body dysfunctions. His conduct therein amounts to gross incompetency in the practice of osteopathy."

The findings were:

"HH. We find the allegations to be substantially supported by the evidence."

The testimony of one Dr. Harold Rosenberg was offered in support of the charges. Dr. Rosenberg stated several times taht he was not an expert as to hypoglycemia [Record p. 750] He testified that he had ordered laboratory tests for Jan Stevens. A Laboratory report of the Wasatch Pathologic Laboratories, Salt Lake City, bearing a hand-written notation "Stevens, Jan" was identified by him, and he based various of his medical conclusions thereon. For example, as to whether or not Jan Stevens had a condition of hypoproteinemia, Dr. Rosenberg testified: "No, I don't see any evidence of that judging from her general chemistry surveys." [Record p. 744] Likewise, the Doctor testified that he saw no evidence of multiple mineral deficiencies and imbalances, or subclinical hypoadrenocorticism. [Record p. 744] As to the presence of any acne, he stated, "Is there any notation made on that? I think she may have had a few acne form - that wasn't very impressive though." [Record p. 744]

After giving testimony Dr. Rosenberg upon cross examination realized that he had been testifying from a laboratory report relating to one "Conrad Hintze", not a report relating to Jan Stevens. when this was called to his attention, he stated [Record p. 754]: "I am suggesting that we contact the Wasatch Pathological Laboratories and find out what the truth of the matter is."

Later in the proceeding Prosecutor Halgren announced, "We have obtained on Jan Stevens a correct laboratory report from Wasatch Laboratories. I have given a copy to counsel and I would like to substitute or include it in that particular exhibit." [Record p. 868] However, Dr. Rosenberg never testified concerning the right laboratory report, or as to his conclusions therefrom.

Overall, as to the charges involving Jan Stevens, only the flimsiest, insubstantial, and unreliable evidence was adduced, and the findings were not supported by a preponderance of the evidence, and the decision is arbitrary and capricious.

POINT VI

THE DISTRICT COURT ERRED BY TREATING THE CASE AS A REVIEW INSTEAD OF AN "ACTION"

The appeal of hearings before the Department of Registration is controlled by the provisions of Utah Code Annotated 1953 § 58-1-36 which provides:

> "... any person directly affected or aggrieved by any ruling of the department of registration, may within thirty days after notice of such ruling institute AN ACTION in

the District Court of the county ... against the director in his official capacity. ..."

This Court in the case of Withers v. Golding 100 Utah 179, 111 P2d 550 (1949) concluded that the purpose of the legislature in enacting this section, was not merely to provide review similar to certiorari, but to confer upon the District Court power to inquire into those grievances set out in the Plaintiff's Complaint touching the entire proceedings before the department, including claim that findings were contrary to the weight of the evidence; to include issues raised by the pleadings before the Court.

The District Court in this matter concluded in its denial of Plaintiff's Motion to Dismiss:

> Even if the decision of the Committee were voidable by reason of Dr. Greenwood's lack of qualifications to sit thereon, it could only be voided at the instance of an agrieved party who has made a timely protest. Appellant raises the point for the first time on appeal and his objection is untimely." [Record P. 127]

The Courts ruling was clearly erroneous, since if the appeal is a new action, the Court must consider all issues raised by the Plaintiff on appeal, which includes the disqualification of the board member, raised during the appeal, as well as other issues raised in the pleadings.

POINT VII

THE DISTRICT COURT ERRED BY FAILING TO APPLY THE "PREPONDERANCE OF EVIDENCE" RULE TO TEST THE VALIDITY OF THE COMMITTEE'S FINDINGS

This Court has determined that in license revocation

proceedings involving an appeal from the decision of the Department of Registration

> "...the Court should determine as on an appeal in equity whether the findings of the committee are contrary to the CLEAR PREPONDERANCE OF THE EVIDENCE before it, rather than to determine merely whether there is any substantial evidence to support such findings." Withers v. Golding, 111 P2d 550 100 Utah 179 (1941)

In addition to the fact that the District Court erroneously upheld a disqualified committee's revocation of Appellant's license, and erroneously treated the case as a review only refusing to allow any introduction of evidence in this "new action" as allowed by Statute and concluded the matter solely based on its review of the transcript in the committee hearing. The Court then failed to apply the "clear preponderance of the evidence" test and instead concluded as follows:

> "The Committee was unusually cautious in its specific allegations in paragraph 8 of the Petition, for example the Committee made "no findings" on 27 out of the 34, apparently not finding there to be sufficient evidence upon which to base any findings." [Record p. 250]

A reading of the transcript will show that the Department of Registration only presented evidence on one of the other 27, and the committee's failure to make findings had nothing to do with their being "unusually cautious" as concluded by the District Court.

In addition the District Court then concluded:

> This Court may not substitute its judgment on factual matters for that of the

> fact finding body unless that body has clearly acted capriciously or arbitrary, or UNLESS ITS CONCLUSIONS ARE UNSUPPORTED BY THE EVIDENCE. (Emphasis added) [Record p. 250]

The District Court erred in its application of the evidentiary standard, in its handling of the "action" as a review only, and in its total failure to weigh the evidence and determine whether the preponderance of the evidence supported the findings of the committee: The District Court errors, totally deprived the Appellant of due process protection and the right to have his "action" heard in accordance with the standards established by the laws of the State of Utah, and the standards established by the Court.

CONCLUSION

In the case at bar, the Osteopathic Committee hearing this case, albeit an improperly constituted body, have become an unauthorized judicial body, which has acted without compliance to the statutes which created it, and together with the director of the Department of Registration, have misapplied the law, and the evidence, in violation of the Plaintiff's constitutional rights afforded by the protections of due process of law, having revoked the license of this eminently qualified physician; to practice medicine, based on standards never before established, in total contravention of the standards recognized and testified to by the Doctors own peers in the practice of preventative medicine. The Appellant respectfully urges the Court to reverse the revocation action of the Department of Registration

(erroneously affirmed by the District Court) and restore the Appellant's license to practice osteopathic medicine in the State of Utah.

Respectfully submitted this 18th day of March, 1982.

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M. Richard Walker

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Plaintiff/Appellant